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5. Managing Control Information (Organizations)

This section is to be completed with information about all organizations that manage the day-to-day operations of the enrolling practitioner's practice. See instructions for an explanation of organizations that should be reported here. If there is more than one management organization, copy and complete this section as needed.

A. Check here ☐ if this section does not apply and skip to Section 6.

B. Organization with Managing Control—Identification Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Legal Business Name as Reported to the IRS		
2. "Doing Business As" Name (if applicable)		
3. Business Address Line 1 (Street Name and Number)		
Business Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
4. Tax Identification Number	Medicare Identification Number(s) or NPI(s) (if applicable)	

6. Managing Employee Information (Individuals)

This section is to be completed with personal identification information about all managing employees. See instructions for the definition of managing employee to determine who should be reported here. If there are more than three managing employees, copy and complete this section as needed.

A. Check here ☐ if this section does not apply and skip to Section 8.

B. 1st Managing Employee - Identifying Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.	
2. Title	Date of Birth (MM/DD/YYYY)			
3. Social Security Number	Medicare Identification Number or NPI (if applicable)			

C. 2nd Managing Employee - Identifying Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.	
2. Title	Date of Birth (MM/DD/YYYY)			
3. Social Security Number	Medicare Identification Number or NPI (if applicable)			

D. 3rd Managing Employee - Identifying Information

☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Name First	Middle	Last	Jr., Sr., etc.	
2. Title	Date of Birth (MM/DD/YYYY)			
3. Social Security Number	Medicare Identification Number or NPI (if applicable)			

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SECTION 7: CHAIN HOME OFFICE INFORMATION

This section has been intentionally omitted.

SECTION 8: BILLING AGENCY

The purpose of collecting this information is to develop effective monitoring of agents/agencies that prepare and/or submit claims to bill the Medicare program. A billing agency is a company or individual you hired or contracted with to furnish claims processing functions for your practice. Any entity that meets this description must be reported in this section.

A. Check Box - If you do not have a billing agency, check the box and skip to Section 10.

B. Billing Agency Name and Address - Indicate if you are adding or deleting a billing agent and/or making a change concerning your existing relationship with your billing agency. Provide the new information and the effective date of the change. Provided that this is the only change you are making, you will need to sign and date the certification statement. Otherwise, if you use a billing agency:

1. Provide the billing agency's legal business name and tax identification number.

2. If the billing agency has a "doing business as" name, provide that information in this space.

3. Provide the street address, telephone number, fax number and e-mail address of the billing agency.

C. Billing Agreement/Contract Information - If reporting a change to existing information about a previously reported billing agreement/contract, check "Change," provide the effective date of the change, complete this entire questionnaire, and sign and date the certification statement. Otherwise:

You are responsible for answering the questions listed.

These questions are designed to show that you fully understand and comprehend your billing agreement and that you intend to adhere to all Medicare laws, regulations, and program instructions. If you do not understand a question or you need help in interpreting your agreement, contact the Medicare carrier. At any time, the carrier may request copies of all agreements/contracts associated with this billing agency.

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7. Chain Home Office Information — This Section Not Applicable

8. Billing Agency

This section is to be completed if you use or contract with a billing agency to submit claims to Medicare on your behalf. If you use more than one billing agency, copy and complete this section for each. You may be required to submit a copy of your current signed billing agreement/contract if Medicare cannot verify the information furnished in this section.

A. Check here ☐ if this section does not apply and skip to Section 10.

B. Billing Agency Name and Address ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

1. Legal Business Name as Reported to the IRS	Tax Identification Number
2. "Doing Business As" Name (if applicable)	
3. Business Street Address Line 1	
Business Street Address Line 2	

City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (optional) ( )	E-mail Address (optional)

C. Billing Agreement/Contract Information ☐ **Change** **Effective Date:**_____

Answer the following questions about your agreement/contract with the above billing agency.

1. Do you have unrestricted access to your Medicare remittance notices? ☐ YES ☐ NO

2. Does your Medicare payment go directly to you? ☐ YES ☐ NO
IF NO, proceed to Question 3.
IF YES, skip Questions 3, 4 and 5.

3. Does your Medicare payment go directly to a bank? ☐ YES ☐ NO
IF NO, proceed to Question 4.
IF YES, answer the following questions and skip Questions 4 and 5.
a) Is the bank account in your name only? ☐ YES ☐ NO
b) Do you have unrestricted access to the bank account and statements? ☐ YES ☐ NO
c) Does the bank only answer to you regarding what you wants from the bank (e.g., sweep account instructions, bank statements, closing account, etc.)? ☐ YES ☐ NO

4. Does your Medicare payment go directly to your billing agent? ☐ YES ☐ NO
IF NO, proceed to Question 5.
IF YES, answer the following question and skip Question 5.
a) Does the billing agent cash your check? ☐ YES ☐ NO
IF NO, proceed to Question b.
IF YES, are <u>all</u> of the following conditions included in the billing agreement?
1) The agent receives payment under an agency agreement with you. ☐ YES ☐ NO
2) The agent's compensation is not related in any way to the dollar amounts billed or collected. ☐ YES ☐ NO
3) The agent's compensation is not dependent upon the actual collection of payment. ☐ YES ☐ NO
4) The agent acts under payment disposition instructions that you may modify or revoke at any time. ☐ YES ☐ NO
5) In receiving payment, the agent acts only on your behalf (except insofar as the agent uses part of that payment as compensation for the agent's billing and collection services). ☐ YES ☐ NO
b) Does the billing agent either give the Medicare payment directly to you or deposit the payment into your bank account? ☐ YES ☐ NO

5. Who receives your Medicare payment?_____

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SECTION 9: FOR FUTURE USE

This section is being reserved for possible future use.

SECTION 10: STAFFING COMPANY

A staffing company is an organization that contracts with health care professionals to furnish health care at medical facilities (such as hospital emergency rooms) where it is also under contract (or some similar agreement) to furnish such services. A staffing company cannot bill Medicare in the staffing company's name for medical services or supplies furnished under this arrangement. If you have an agreement/contract with a staffing company to furnish services to Medicare beneficiaries, complete this section. At any time, the carrier can request a copy of the agreement/contract signed by you and the staffing company.

A. Check Box - If you do not work for (or do not contract with) a staffing company, check this box and skip to Section 13.

B. Staffing Company Name and Address - Indicate if you are "adding," "deleting," or "making a change," concerning your relationship with an existing staffing company by checking the appropriate box. Provide the new information and the effective date of the change, and sign and date the certification statement. Otherwise:

1. Furnish the legal business name and tax identification number of the staffing company.

2. If applicable, furnish the staffing company's "doing business as" (DBA) name. If the reported staffing company uses more than one DBA name with you, report all that apply for Medicare claims.

3. Furnish the complete mailing address, telephone number, fax number and e-mail address for the staffing company.

C. Staffing Company Contract/Agreement Information

Respond to the questions asked in this section to indicate that you fully understand and comprehend your contract with the staffing company and that you plan to adhere to all Medicare laws, regulations, and program instructions. At any time, the carrier can request a copy of the agreement/contract signed by you and the staffing company.

SECTION 11: SURETY BOND INFORMATION

This section has been intentionally omitted.

SECTION 12: CAPITALIZATION REQUIREMENTS FOR HOME HEALTH AGENCIES

This section has been intentionally omitted.

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9. For Future Use — This Section Not Applicable

10. Staffing Company

This section is to be completed if you are under contract to render medical services with a company that staffs health care organizations (e.g., hospital emergency rooms) with medical professionals to treat patients. If you are under contract with more than one staffing company, copy and complete this section for each. You may be required to submit a copy of your current signed staffing company agreement/contract.

A. Check here ☐ if this section does not apply and skip to Section 13.

B. Staffing Company Name and Address ☐ Add ☐ Delete ☐ Change Effective Date:_____

1. Legal Business Name as Reported to the IRS	Tax Identification Number	
2. "Doing Business As" Name (if applicable)		
3. Business Street Address Line 1 (Street Name and Number)		
Business Street Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
Telephone Number (Ext.) ( ) ( )	Fax Number (optional) ( )	E-mail Address (optional)

C. Staffing Company Contract/Agreement Information

Answer the following questions about the staffing company and your contract/agreement with it.

1. If you have a contract/agreement with both a billing agency and a staffing company, does the staffing company shown in Section 9B **and** the billing agency identified in Section 8B have a common owner(s)? ☐ Not applicable ☐ YES ☐ NO

2. If you have a contract/agreement with both a billing agency and a staffing company (even if the billing agency and staffing company are the same), are there any provisions in your staffing company contract/agreement that supersede or contradict your billing agreement? ☐ Not applicable ☐ YES ☐ NO

11. Surety Bond Information — This Section Not Applicable

12. Capitalization Requirements for Home Health Agencies — This Section Not Applicable

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SECTION 13: CONTACT PERSON INFORMATION - OPTIONAL

To assist in the timely processing of your application, you may want to provide the full name, e-mail address, telephone number, and mailing address of an individual who can be reached to answer questions regarding the information furnished in this application (preferably the individual who completed this application if other than yourself). You are not required to furnish a contact person in this section. It should be noted that if a contact person is not provided, all questions about this application will be directed to you.

A. Check Box - If you do not have a contact person, check this box and skip to Section 14.

B. Contact Person Information - Indicate if you are completing this section to add or delete a contact person currently on file. State the effective date of the change. If you are changing existing information, check the applicable box and provide the effective date of the change, and sign and date the certification statement. Otherwise:

- Furnish the full name, mailing address, e-mail address, and telephone number of an individual who can answer questions about the information furnished in this application.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION

This section explains the penalties for deliberately furnishing false information to acquire or maintain enrollment in the Medicare program. You should review this section to ensure that you understand those penalties that can be applied against you for deliberately furnishing false information in this Medicare enrollment application.

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13. Contact Person Information (Optional)

This section is to be completed with the name and telephone number of a person, other than yourself, who can answer questions about the information furnished in this application (preferably the individual who completed this application). You do not need to furnish any name if you want all questions directed to you.

A. Check here ☐ if this section does not apply and skip to Section 14.

B. Contact Person Information ☐ **Add** ☐ **Delete** ☐ **Change** **Effective Date:**_____

Name First	Last	
Address Line 1 (Street Name and Number)		
Address Line 2 (Suite, Room, etc.)		
City	State	ZIP Code + 4
E-mail Address (if applicable)	Telephone Number ( )	(Ext.) ( )

14. Penalties for Falsifying Information on this Enrollment Application

This section explains the penalties for deliberately furnishing false information in the application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.

The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
   a.) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
   b.) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c.) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government.

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:
   a.) was not provided as claimed; and/or
   b.) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

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SECTION 15: CERTIFICATION STATEMENT

As an individual practitioner, you are the only person who can sign this application. This applies not only to initial enrollment and revalidation, but also to any changes and/or updates (e.g., new practice locations, change in specialties, address changes, etc.) to your status in the Medicare program. The authority to sign the application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

By signing the Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry to or revoked from the Medicare program if any requirements are not met. **Your signature must be an original.** Faxed, photocopied, or stamped signatures will not be accepted.

SECTION 16: DELEGATED OFFICIAL

This section has been intentionally omitted.

SECTION 17: ATTACHMENTS

This section contains a list of documents that, if applicable, must be submitted with this enrollment application. Failure to provide the required documents will delay the enrollment process.

- Check the appropriate boxes indicating which documents are being submitted with this application.

NOTE: Any licenses (both business and professional) that are required by the State where your practice is located **must** be included with this application.

All enrolling practitioners are required to furnish information on all Federal, State and local (city/county) professional and business licenses, certifications and/or registrations as required by the practitioner's State to operate as a health care supplier (e.g., CLIA and FDA mammography certificates, hazardous waste disposal license, etc.). The Medicare contractor will supply specific licensing requirements for your supplier type upon request.

In lieu of copies of the above requested documents, you may submit a notarized Certificate of Good Standing from the State licensing/certification board or other medical associations. This certification cannot be more than 30 days old.

If you have had a previously revoked or suspended license, certification, or registration reinstated, attach a copy of the reinstatement notice with this application.

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15. Certification Statement

You **MUST** sign and date the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

I, the undersigned, certify to the following:

1.) I have read the contents of this application, and the information contained herein is true, correct, and complete to the best of my knowledge. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare program contractor of this fact immediately.

2.) I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of any future changes to the information contained in this form within 90 days of the effective date of the change. I understand that any change in my status as an individual practitioner may require the submission of a new application.

3.) I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.

4.) I agree to abide by the Medicare laws, regulations and program instructions that apply to me. The Medicare laws, regulations, and program instructions are available through the Medicare contractor.

5.) Neither I, nor any managing employee, is currently sanctioned, suspended, debarred, or excluded by the Medicare or Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.

6.) I agree that any existing or future overpayment made to me by the Medicare program may be recouped by Medicare through the withholding of future payments.

7.) I understand that the Medicare billing number issued to me can only be used by me or by a provider or supplier to whom I have reassigned my benefits under current Medicare regulations, when billing for services rendered by me.

8.) I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

9.) I further certify that I am the individual practitioner who is applying for Medicare billing privileges.

Practitioner Name **Print** First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Practitioner **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY) Signed	

16. Delegated Official — This Section Not Applicable

17. Attachments

This section is a list of documents that, when applicable, should be submitted with this completed enrollment application.

Place a check next to each document (as applicable or required) that you are including with this completed application.

- ☐ Copy(s) of all Federal, State, and/or local (city/county) professional licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐ Copy(s) of all Federal, State, and/or local (city/county) business licenses, certifications and/or registrations specifically required to operate as a health care facility
- ☐ Copy(s) of all certificates or evidence of qualifying course work
- ☐ Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates
- ☐ Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)
- ☐ Completed Form HCFA-460 – Medicare Participating Physician or Supplier Agreement
- ☐ Completed Form HCFA-588 - Authorization Agreement for Electronic Funds Transfer
- ☐ Completed Form CMS 855R – Individual Reassignment of Benefits
- ☐ IRS documentation confirming the Tax Identification Number with the Legal Business Name (e.g., CP 575)
- ☐ Any additional documentation or letters of explanation as needed

MEDICARE

FEDERAL HEALTH CARE
REASSIGNMENT OF BENEFITS APPLICATION

Application for Individual Health Care Practitioners to Reassign Medicare Benefits

CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS 855R (01/2003)

OMB Approval No. 0938-0685

Keep a copy of this completed package for your own records.

Upon completion, return this application and all necessary documentation to:

OMB Approval No. 0938-0685

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Provider/Supplier Enrollment Application

Privacy Act Statement

The Centers for Medicare and Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers/suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers or suppliers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS), and either system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in Vol. 61 of the Federal Register at page 20,528 (May 7, 1996)), or the National Provider Identifier (NPI) System, Office of Management and Budget (OMB) approval 0938-0684 (R-187). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1) CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2) A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3) The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4) Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5) To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6) To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7) To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the Unique Physician Identification Number Registry is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8) An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9) Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10) State Licensing Boards for review of unethical practices or non-professional conduct;
11) States for the purpose of administration of health care programs; and/or
12) Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process provider's/supplier's health care claims.

The enrolling provider or supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

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INDIVIDUAL REASSIGNMENT OF MEDICARE BENEFITS INSTRUCTIONS

Please **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information may cause this form to be returned and delay the processing of your reassignment. This application is to be completed for any **individual practitioner** who will be reassigning his or her benefits to an eligible provider or supplier. See inside front cover for return mailing instructions. Electronic copies of all CMS Medicare enrollment forms can be found at the Medicare web-site at http://www.cms.hhs.gov. These electronic forms may be downloaded to your computer, completed on screen, printed, signed, and mailed to the appropriate Medicare contractor.

SECTION 1: GENERAL INFORMATION

Check the applicable box indicating the reason for the submittal of this application.

Add a New Reassignment – Check this box and furnish the effective date when an individual practitioner who is enrolling or is currently enrolled in the Medicare program will be reassigning his/her benefits to this provider/supplier for the 1st time. The provider/supplier **must** be enrolled or currently enrolling in Medicare before a reassignment can be effectuated. When adding a reassignment, complete Sections 1, 2, 3, 5, 6 and 7.

Terminate a Current Reassignment – Check this box and furnish the effective date when an individual practitioner who has reassigned his/her benefits to this provider/supplier is terminating that reassignment. No reassigned claims will be paid to the provider/supplier for services rendered by the practitioner identified in Section 3 after the effective date of deletion.

- When the group/clinic is terminating the reassignment, the group/clinic must complete Sections 1, 2, 3, 6, and 7.
- When the individual practitioner is terminating the reassignment, he/she must complete Sections 1, 2, 3, 4, and 7.

Change Income Reporting Status – Check this box and furnish the effective date when reporting a change in the type of income tax withholding (e.g., if a practitioner changes his/her work status from "Employee" to "Independent Contractor") reported to the IRS for the individual practitioner who has reassigned his/her benefits to this provider/supplier. When changing the practitioner's income reporting status, complete Sections 1, 2, 3, 6 and 7.

Attesting to Current Reassignment – Check this box if you have been requested to declare all those groups or other entities you are affiliated with in which you have current valid reassignment of benefits established. All individuals that have 5 or more active reassignments with 5 or more groups/entities are required to confirm this information periodically. You will need to complete a separate CMS 855R for each group/entity to whom you reassign your benefits. When attesting to current reassignments complete Sections 1, 2, 3, 5, and 7.

NOTE: All changes must be reported to the carrier within 90 days of the effective date of the change.

SECTION 2: PROVIDER/SUPPLIER IDENTIFICATION

This section is to be completed with information about the provider/supplier to which the individual practitioner's benefits will be reassigned or have already been reassigned.

NOTE: Prior to the reassignment of benefits to this provider/supplier, both the individual practitioner **AND** the provider/supplier must be enrolled (or concurrently enrolling) in the Medicare program. If the individual practitioner's or the provider/supplier's initial enrollment application is being submitted concurrently with this reassignment application, write **"pending"** in the Medicare identification number block.

Furnish the provider/supplier's name and tax identification number as reported to the IRS, and the provider/supplier's group specialty and Medicare identification number or National Provider Identifier (NPI).

NOTE: The provider/supplier's name as reported to the IRS must be the same as reported on the provider/supplier's CMS 855B when it enrolled.

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SECTION 3: INDIVIDUAL PRACTITIONER IDENTIFICATION

This section is to be completed for each individual practitioner who is reassigning (or terminating reassignment) of his or her Medicare benefits to the provider/supplier shown in Section 2 of this form.

- Furnish the individual's full given name, social security number, Medicare identification number or National Provider Identifier (NPI), and specialty.

- Indicate what income reporting form the individual receives from the provider/supplier based on his/her employment with the provider/supplier.

NOTE: Prior to the reassignment of benefits to this provider/supplier, both the individual practitioner **AND** the provider/supplier must be enrolled (or concurrently enrolling) in the Medicare program. If the individual practitioner's or the provider/supplier's initial enrollment application is being submitted concurrently with this reassignment application, write **"pending"** in the Medicare identification number block.

Payroll Agent - If the provider/supplier utilizes an IRS approved Payroll Agent to pay the salaries of W-2 employees reassigning their benefits, the provider/supplier must submit copies of the completed IRS Form 2678 (Employer Appointment of Agent), and the letter (IRS Form 1997C) authorizing the appointment of a payroll agent signed by the IRS Service Center Director. These IRS forms will be used as documentation to establish the employer-employee relationship required under § 3060.1 of the Medicare Carriers Manual.

If the individual practitioner receives a form other than those listed in this section, check "Other" and identify the form.

In situations where a provider/supplier contracts with an organization (e.g., a physician group practice) for physician/practitioner services and there is no direct payment to the physician/practitioner from the provider/supplier, the "Other" block for income reporting should be used and the description should indicate **indirect contractual arrangement (ICA)**.

NOTE: To reduce the burden of furnishing some types of supporting documentation, we have designated specific types of documentation to be furnished on an "as needed" basis. However, the carrier may request, at any time, documentation to support or validate information that is reported in this application. Some examples of documents that may be requested for validation are IRS W-2s, pay stubs, or employment contracts.

OMB Approval No. 0938-0685

MEDICARE FEDERAL HEALTH CARE BENEFIT REASSIGNMENT APPLICATION

Application for the Reassignment of Medicare Benefits

General Instructions

The Medicare Federal Health Care Benefit Reassignment Application has been designed by the Centers for Medicare and Medicaid Services (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are only paid to qualified health care providers or suppliers with whom an individual practitioner has a valid reassignment of benefits on file with Medicare, and that the amount of the payments are correct. To accomplish this, Medicare must know basic identifying information about the individual practitioner and the provider/supplier who the individual practitioner is authorizing to receive payment on his or her behalf for services rendered to Medicare beneficiaries.

When completing this application, Medicare must know the name, social security number, and Medicare identification number of the individual practitioner reassigning his or her benefits and the name, tax identification number, and Medicare identification number of the provider/supplier receiving the individual practitioner's reassigned benefits.

This application must be completed any time an individual practitioner reassigns his or her benefits to an eligible provider/supplier. Both the individual practitioner and the eligible provider/supplier must be currently enrolled (or concurrently enrolling) in the Medicare program. Generally, this application will be completed by the provider/supplier, signed by the individual practitioner, and submitted by the provider/supplier. When deleting a current reassignment, either the provider/supplier **or** the individual practitioner may submit this application with the appropriate sections completed.

1. General Information

This section is to be completed with information as to why this reassignment of benefits application is being submitted.

Reason for Submittal of this Application

Check one:

- ☐ Add a New Reassignment – Effective Date:_____
- ☐ Terminate a Current Reassignment – Effective Date:_____
- ☐ Change Income Reporting Status - Effective Date (MM/DD/YYYY):_____
- ☐ Attesting to Current Reassignment

2. Provider/Supplier Identification

This section is to be completed with identifying information about the provider/supplier to which the individual practitioner is reassigning his or her benefits.

Legal Business Name of Provider/Supplier as Reported to IRS	Group Specialty
Tax Identification Number	Medicare Identification Number or NPI

3. Individual Practitioner Identification

This section is to be completed with identifying information about the individual practitioner who will be reassigning (or terminating the reassignment of) his or her benefits to the provider/supplier shown in Section 2 above.

Name First	Middle	Last	Jr., Sr., etc.
Social Security Number	Medicare Identification Number or NPI	Practitioner Specialty	

What income reporting form does the individual practitioner receive from the supplier at the end of the calendar year based on his or her relationship with the provider/supplier shown in Section 2?

Check all that apply: ☐ **W-2** ☐ **1099** ☐ **1065-K1** **Other:**_____

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SECTION 4: STATEMENT OF TERMINATION

This section is to be completed only if you are terminating your reassignment of benefits to the provider/supplier.

- Furnish the provider/supplier's name as reported to the IRS (the name must be the same as reported in Section 2).
- Complete, sign, and date the "Statement of Termination."

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

By his or her signature, the individual practitioner terminates the authority of the provider/supplier to claim or receive any fees or charges for the practitioner's services, and attests to the accuracy of the information provided on this form.

SECTION 5: REASSIGNMENT OF BENEFITS STATEMENT

The individual practitioner who will be reassigning benefits to the eligible provider/supplier must complete, sign, and date this Reassignment of Benefits Statement. Failure to do so will delay the processing of this application, thus limiting CMS's ability to make payments.

- Type or print the individual practitioner's full name.
- The individual practitioner must sign and date this section.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

SECTION 6: ATTESTATION STATEMENT

Either the authorized official or a delegated official who has been identified on the provider/supplier's CMS 855B application must sign and date this Attestation Statement. By his or her signature, the authorized or delegated official attests to the accuracy of the information provided and certifies that the provider/supplier applying to receive or terminate payments is in fact eligible to receive or terminate reassigned benefits.

NOTE: All signatures must be original. Faxed, photocopied, or stamped signatures are not acceptable.

For further information on the requirements regarding the reassignment of benefits, contact the Medicare carrier.

SECTION 7: CONTACT PERSON

Provide the full name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated at 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

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4. Statement of Termination

This section is to be completed by the individual practitioner to terminate a previously authorized reassignment of benefits.

By my signature, I hereby terminate the authority of _____ to claim or receive any fees or charges for my services. (Name of Individual or Provider/Supplier as Reported to the IRS)

I certify that I have examined the above information and that it is true, accurate and complete to the best of my knowledge. I understand that any deliberate misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner Name **Print** First	Middle	Last	Jr., Sr., etc.

Individual Practitioner Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed

5. Reassignment of Benefits Statement

This section **MUST** be signed and dated by the individual practitioner shown in Section 3 to authorize the reassignment of his or her benefits to the provider/supplier shown in Section 2.

Medicare law prohibits payment for services provided by an individual practitioner to be paid to another individual or provider/supplier unless the individual practitioner who provided the services specifically authorizes another individual or provider/supplier (employer, facility, or health care delivery system) to receive said payments in accordance with 42 CFR 424.73 and 42 CFR 424.80. By signing this Reassignment of Benefits Statement, you are authorizing the individual or provider/supplier identified in Section 2 to receive Medicare payments on your behalf.

Your employment or contract with this individual or provider/supplier must be in compliance with CMS regulations. All individual practitioners who allow another individual or provider/supplier (employer, facility, or health care delivery system) to receive payment for their services must sign the Reassignment of Benefits Statement.

Individual Practitioner Name **Print** First	Middle	Last	Jr., Sr., etc.

Individual Practitioner **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed

6. Attestation Statement

This section requires the signature of an authorized or delegated official of the provider/supplier shown in Section 2. The authorized or delegated official must currently be on file with Medicare for this application to be processed.

I certify that I have examined the above information and that it is true, accurate and complete to the best of my knowledge. I understand that any deliberate misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws. For new reassignments, I also certify that the provider/supplier requesting to receive payments is legally eligible to receive reassigned benefits per CMS regulations.

Authorized/Delegated Official Name **Print** First	Middle	Last	Jr., Sr., etc.

Authorized/Delegated Official **Signature** (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY) Signed

7. Contact Person

This section is to be completed with the name, telephone number and address of a person who can answer questions about the information furnished in this application.

Name First	Last	Telephone Number (Ext.) ( ) ( )

Address Line 1 (Street Name and Number)		
City	State	ZIP Code + 4

MEDICARE

FEDERAL HEALTH CARE
PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

CENTERS FOR MEDICARE & MEDICAID SERVICES

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Keep a copy of this complete package for your own records

Upon completion, return this application and all necessary documentation to:

National Supplier Clearinghouse
Post Office Box 100142
Columbia, South Carolina 29202-3142

Telephone Number 1 (866) 238-9652

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Medicare Provider/Supplier Enrollment Application

Privacy Act Statement

The Centers for Medicare and Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395l(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers/suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers or suppliers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as "optional" on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS), and either system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in Vol. 61 of the Federal Register at page 20,528 (May 7, 1996), or the National Provider Identifier (NPI) System (OMB) approval 0938-0684 (R-187). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1) CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2) A congressional office from the record of an individual health care provider/supplier in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3) The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4) Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5) To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6) To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7) To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the Unique Physician Identification Number Registry is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8) An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9) Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers/suppliers of medical services/supplies or to detect fraud or abuse;
10) State Licensing Boards for review of unethical practices or non-professional conduct;
11) States for the purpose of administration of health care programs; and/or
12) Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process provider's/supplier's health care claims.

The provider or supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

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INSTRUCTIONS FOR APPLICATION FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) SUPPLIERS

Please be sure to **PRINT** or **TYPE** all information so it is legible. Do not use pencil. Failure to provide all requested information might cause the application to be returned and may delay the enrollment process. Certain sections of the application have been omitted because they do not apply to DMEPOS suppliers. See inside front cover for mailing instructions. Electronic copies of all CMS Medicare enrollment forms can be found at the Medicare website at http://www.cms.hhs.gov. These electronic forms may be downloaded to your computer, completed on screen, printed, signed, and mailed to the appropriate Medicare contractor.

Whenever additional information needs to be reported within a section, copy and complete that section for each additional entry. We strongly suggest that the DMEPOS supplier keep a photocopy of its completed application and supporting documents for future reference.

This application is to be completed by DMEPOS suppliers that will bill Medicare carriers for Durable Medical Equipment, Prosthetics, Orthotics, or Supplies provided to Medicare beneficiaries. Failure to promptly submit a completed form CMS 855S to the National Supplier Clearinghouse will result in delays in obtaining enrollment and billing privileges.

DEFINITIONS OF MEDICARE ENROLLMENT TERMINOLOGY

To help you understand certain terms used throughout the application, we have included the following definitions:

Authorized Official-An appointed official to whom the supplier has granted the legal authority to enroll the supplier in the Medicare program, to make changes and/or updates to the supplier's status in the Medicare program (e.g., new practice locations, change of address, etc.) and to commit the supplier to fully abide by the laws, regulations, and program instructions of Medicare. The authorized official must be the supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the supplier (see Section 5 for the definition of a "direct owner"), or must hold a position of similar status and authority within the supplier's organization.
Billing Agency-A company that the enrolling supplier contracts with to furnish claims processing functions for the supplier.
Business Location-This is the physical structure from which the enrolling supplier conducts its business operations.
Carrier-The Part B Medicare claims processing contractor.
Delegated Official-Any individual who has been delegated, by the supplier or the supplier's "Authorized Official," the authority to report changes and updates to the supplier's enrollment record. A delegated official **must** be a managing employee (W-2) of the supplier or have a 5% ownership interest, or any partnership interest, in the supplier.
DMEPOS-Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.
DMEPOS Supplier-A business or individual that furnishes Durable Medical Equipment, Prosthetics, Orthotics, or Supplies.
Enrolling Supplier-The enrolling supplier is the actual business location from where DMEPOS items are furnished. All sections of this application must be completed with information related to the "Business Location" reported in Section 4A.
Fiscal Intermediary-The Part A Medicare claims processing contractor.
Legal Business Name-The name reported to the Internal Revenue Service (IRS) for tax reporting purposes.
Medicare Identification Number-This is a generic term for any number that uniquely identifies the enrolling supplier. Examples of Medicare identification numbers are Unique Physician/Practitioner Identification Number (UPIN), National Provider Identifier (NPI), and National Supplier Clearinghouse (number) (NSC).
National Supplier Clearinghouse (NSC)-This is the DMEPOS Medicare enrollment contractor.
Provider-A provider is a hospital, critical access hospital, skilled nursing facility, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice, that has in effect an agreement to participate in Medicare; or a rural health clinic (RHC), Federally qualified health center (FQHC), rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.
Provider Identification Number (PIN)-This number is assigned to providers, suppliers, groups and organizations in Medicare Part B. This number will identify who provided the service to the beneficiary on the Medicare claim form.
Supplier-A physician or other practitioner, or an organization other than a provider, that furnishes health care services under Medicare Part B. The term supplier also includes independent laboratories, portable x-ray services, physical therapists in private practice, end stage renal disease (ESRD) facilities, and chiropractors. For enrollment purposes, suppliers who submit claims for durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS) must complete the CMS 855S.
Tax Identification Number (TIN)-The number issued by the IRS and used to report tax information to the IRS.

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SECTION 1: GENERAL APPLICATION INFORMATION

This section is to identify the reason for submittal of this application. It will also indicate whether the supplier currently has a business relationship with Medicare.

A. Reason for Submittal of this Application - This section identifies the reason this application is being submitted.

1. Select one of the following:

Initial Enrollment of a New DMEPOS Supplier:
- If the supplier is enrolling in the Medicare program for the first time as a DMEPOS supplier.

Re-enrollment:
- If the supplier is currently enrolled in the program and has been asked to verify and update the enrollment information currently on file, and to attest that it is still eligible to receive Medicare payments.

Reactivation:
- If the supplier's Medicare billing number was deactivated.

To reactivate billing privileges, the supplier may be required to either submit an updated CMS 855S or certify to the accuracy of its enrollment information currently on file with CMS. In addition, prior to being reactivated, the supplier must be able to submit a valid claim. The supplier must also meet all current Medicare requirements as a DMEPOS supplier regardless of whether it was previously enrolled in the program.

Enrollment of a New Location for a Currently Enrolled DMEPOS Supplier:
- If the supplier is currently enrolled in the program and is applying to enroll a new business location.

Change of Information:
- If the supplier is adding, deleting, or changing existing information under this tax identification number.

If an existing supplier changes its name/owner/address, etc., the supplier must annotate the change by checking the section(s) where the change is going to be made, completing the appropriate section(s), and signing and dating the certification statement. For example, if an existing supplier is moving to a new location and has previously completed an application, the supplier completes Sections 1, 4, and 14. The supplier does not complete a full application. When reporting a change of information, always complete Section 1 to identify the supplier and provide the new/changed information in the section checked, and sign and date the certification statement (Section 14). **All changes must be reported to the NSC within 30 days of the effective date of the change.**

Voluntary Termination of Billing Number:
- If the supplier will no longer be submitting claims to the Medicare program using this billing number.

Voluntary termination ensures that the supplier's billing number will not be fraudulently used if the supplier ceases its Medicare operations. Provide the date operations ceased or the date the supplier will stop billing for Medicare covered services and the billing number to be terminated. In addition, complete Section 1 to identify the supplier and sign and date the certification statement (Section 14).

NOTE: "Voluntary Termination" **cannot** be used to circumvent any corrective action plan or any pending/ongoing investigation.

NOTE: Suppliers must furnish their current NSC billing number in the space provided if submitting this application for any reason other than the initial enrollment of a new DMEPOS supplier.

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2. This section identifies the State where the supplier's business location (as reported in Section 4A) is located. Please indicate the two-letter state code for the State where the supplier's business is located (for example, "SC" for "South Carolina").

3. Supplier numbers can be used nationally when filing claims; however, the supplier is required to indicate the region where the majority of claims for this location will be submitted. Claims are submitted based on where the Medicare beneficiary resides. For example, if **most** of the supplier's Medicare beneficiaries reside in MD, DC, and VA, the supplier would check "Region B." See list below to determine the appropriate box(es) to check.

   - **Region A** - Delaware, Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
   - **Region B** - District of Columbia, Illinois, Indiana, Maryland, Michigan, Minnesota, Ohio, West Virginia, Wisconsin, Virginia
   - **Region C** - Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands
   - **Region D** - Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana, Oregon, South Dakota, Utah, Washington, Wyoming

4. Indicate whether the supplier is currently enrolled in another part of the Medicare program (e.g., as a home health agency). If "Yes," provide the name of the Medicare contractor to which the supplier submits claims and its Medicare identification number in this space. Report all currently active Medicare numbers. This is the number used to identify the supplier and is used on claims forms. This number may be referred to as a Medicare provider number, provider identification number (PIN), National Provider Number (NPI), or National Supplier Clearinghouse number. Report all numbers that have been issued to this supplier. Attach an additional page if necessary.

If the supplier does not currently have a Medicare identification number, it will be assigned one upon the successful completion of its enrollment. The supplier will receive information about what number(s) has been issued and how it is to be used.

NOTE: To reduce the burden of furnishing some types of supporting documentation, we have designated specific types of documentation to be furnished on an "as needed" basis. However, the NSC may request documentation, at any time during the enrollment or re-enrollment process, to support or validate information that is reported in this application. Some examples of documents that may be requested for validation are billing agreements, IRS W-2 forms, pay stubs, articles of incorporation, and partnership agreements.

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MEDICARE FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION

Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

General Instructions

The Medicare Federal Health Care Provider/Supplier Enrollment Application has been designed by the Centers for Medicare and Medicaid Services (CMS) to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are paid only to qualified DMEPOS suppliers, and that the amounts of the payments are correct. This information will also identify whether the DMEPOS supplier is qualified to furnish health care items to Medicare beneficiaries. To accomplish this, Medicare must know basic identifying and qualifying information about the DMEPOS supplier that is seeking billing privileges in the Medicare program.

Medicare needs to know: (1) the type of DMEPOS supplier enrolling, (2) what qualifies this DMEPOS supplier to furnish health care related DMEPOS items, (3) where or how this DMEPOS supplier intends to furnish these items, and (4) those persons or entities with an ownership interest or managerial control, as defined in this application, over the DMEPOS supplier.

This application **MUST** be completed in its entirety, unless the appropriate box is checked to indicate the section does not apply or when reporting a change to previously submitted information. If a section does not apply to this DMEPOS supplier, check (√) the appropriate box in that section and skip to the next section. Sections 7, 9, and 11 have been deliberately omitted from this application because they are not applicable to the enrollment of DMEPOS suppliers that bill Medicare carriers.

1. General Application Information

A. Reason for Submittal of this Application

This section is to be completed with general information as to why this application is being submitted and whether this supplier currently has a business relationship with another Federal health care program.
To ensure timely processing of this application, Numbers 1, 2 and 3 below MUST ALWAYS be completed.

1. Check one:
   - ☐ Initial Enrollment of a New DMEPOS Supplier
   - ☐ Re-enrollment Furnish Current Billing Number:_____
   - ☐ Reactivation Furnish Current Billing Number:_____
   - ☐ Enrollment of a New Location for a Currently Enrolled DMEPOS Supplier
     Furnish Current Billing Number:_____
   - ☐ Change of Information (including Ownership) - (Check appropriate Section(s) below).
     ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 15
     Furnish Current Billing Number:_____
   - ☐ Voluntary Termination of Billing Number - Effective Date (MM/DD/YYYY):_____
     Furnish Current Billing Number to be terminated:_____

2. Please indicate the two-letter state code for the state where the enrolling business location is located for this DMEPOS supplier.
   _____ _____ (Example: S C for South Carolina)

3. To which region(s) will this supplier submit the majority of claims for this location?
   ☐ Region A ☐ Region B ☐ Region C ☐ Region D ☐ All Regions

4. Is this supplier currently enrolled in the Medicare program other than as a DMEPOS supplier? ☐ YES ☐ NO
   IF YES, furnish the following information about the current enrollment:

Medicare Contractor Name:_____ Medicare Identification Number or NPI:_____

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SECTION 2: SUPPLIER IDENTIFICATION

A. Supplier IRS Identification Information - This section is to be completed with information specifically related to the business location of the DMEPOS supplier submitting this application.

If reporting a change to existing information, check "Change," provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

1. Provide the legal business name as reported to the Internal Revenue Service (IRS), and the tax identification number (TIN) issued by the IRS to this supplier business location or the TIN used by this business location for tax reporting purposes.

Attach documentation (e.g., a copy of the IRS CP-575) from the IRS showing that the supplier business name matches the name reported in this application. If the supplier does not have an IRS CP-575, any official correspondence from the IRS that shows the supplier's name and TIN will be acceptable proof. Upon request, the IRS will provide a Form 147C showing the supplier's name and TIN.

NOTE: An IRS CP 575 or other documentation must be submitted for each TIN reported on this application.

If the supplier cannot obtain the required IRS document, explain why in a separate attachment and provide evidence that links its legal business name with the reported TIN. If the name and TIN do not match on the submitted documents, explain why and refer to the documents that confirm the identification of the supplier or owner as applicable (e.g., if the supplier recently changed its name and the IRS has not sent it an updated document). The supplier may then submit the old IRS document with the old name, as well as a copy of documentation filed with the IRS and State concerning the name change.

2. Furnish the address where the IRS Form 1099 is to be mailed for this supplier. If the supplier has changed or is changing its tax identification number, furnish the tax identification number currently or previously used and reported to Medicare.

B. Type of Business for this Supplier – Indicate the type of business operated by the supplier at this location.

1. Check all items that apply to the business location for which this application is being submitted.

2. Indicate the primary type of business conducted at the business location for which this application is being submitted.

NOTE: Copies of all Federal, State and local (city/county) professional and business licenses, certifications and/or registrations required to practice as a DMEPOS supplier in the enrolling supplier's State (e.g., Federal Drug Enforcement Agency (DEA) number for pharmacies, business occupancy license, local business license), must be submitted with this application.

C. Products and Services to be Furnished by this Supplier – Provide the types of DMEPOS products and services supplied to Medicare beneficiaries from this business location.

1. If this supplier is a physician, check the box provided and skip to Section D.

2. Indicate all primary products and services furnished by this supplier from this business location by circling the letter "P" next to the product or service **and** indicate all secondary products and services furnished by this supplier from this business location by circling the letter "S" next to the product or service.

NOTE: If "Parenteral Nutrition" and/or "Drugs/Pharmaceuticals" have been checked, a copy of the supplier's State pharmacy license **must** be submitted with this application.

D. Liability Insurance Information – All DMEPOS suppliers enrolling in Medicare must have liability insurance. Furnish the requested information about the insurance company and submit a copy(s) of the supplier's current liability insurance policy (or evidence of self-insurance) with this application.

E. Incorporation Information – Indicate if the supplier's business is incorporated.